

AB 2394
Task Force on Culturally & Linguistically Competent Physicians & Dentists

Working Group on Cultural Competency Standards

Includes Edits as of October 8, 2002

Introduction

The charge of the Working Group on Cultural Competency Standards is to identify “key cultural elements necessary to meet cultural competency by physicians, dentists and their offices”. The Committee has interpreted “their offices” to include health professionals and staff who work directly with patients, as well as other workplaces, including other health care facilities and health care organizations.

The Working Group views the purpose of these key cultural elements as the foundation from which to develop comprehensive standards to guide and ensure access to culturally and linguistically appropriate health care services by patients from various cultures and those who speak limited or no English.

The incorporation of these key cultural elements into the policies, practices, procedures and programs of health care providers and health care organizations, will enable the provider to develop culturally and linguistically competent health care services.

Key Cultural Elements

1. Definition of Culture and Cultural Competency
2. Glossary
3. Relevant Laws, Policies and Accreditation Requirements
4. Cultural and Linguistic Needs Assessment of the Patient
5. Comprehensive Written Policy on Culture and Language
6. Interpreter Services
7. Written Translations – Health Information and Vital Documents
8. Cultural and Linguistic Competency Training and Continuing Education
9. Cultural and Linguistic Program Monitoring, Evaluation & Record Keeping
10. Organizational Accountability
11. Patient Rights
12. Clinical assessment of the patient
13. Cultural Perspectives on Health & Healing

1. Definition of Culture and Cultural Competency

Culture is the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people. Culture influences how clinicians deliver services and how patients respond to medical services and preventive interventions. Culture is determined not only by race or ethnicity but by factors such as national origin, geography, age, language, religion, gender, sexual orientation, differently abled persons, and socioeconomic status. Individuals may identify with more than one cultural group.

There are six essential elements of culture:

- ☐ Culture is learned;
- ☐ Culture refers to systems of meanings;
- ☐ Culture acts as a framework upon which belief systems are built;
- ☐ Culture is taught, reproduced, and may be transmitted intergenerationally;
- ☐ Culture exists in a constant state of change; and
- ☐ Culture includes patterns of both subjective and objective components of human behavior.

Cultural Competency: the delivery of culturally competent health care incorporates pertinent cultural concepts and data in the clinical assessment and treatment of individuals across ethnic and cultural groups. At a minimum, cultural competency skills include:

- ☐ Applying linguistic skills to communicate effectively with the targeted population;
- ☐ Utilizing cultural information to establish therapeutic relationships;
- ☐ Eliciting and incorporating pertinent cultural data in diagnosis and treatment; and
- ☐ Understanding and applying cultural and ethnic data to the process of clinical care.

2. Glossary

See Attachment A

3. Relevant Laws, Policies and Accreditation Requirements

See Attachment B

4. Cultural and Linguistic Needs Assessment of the Patient

The federal Office for Civil Rights (OCR) states that the “first key to ensuring meaningful access is for the recipient/covered entity to assess the language needs of the affected population.” OCR further delineates that the covered entity (health care provider and organization) should assess the language needs of the population to be served by identifying: languages likely to be encountered, number of limited English proficient persons (LEP) eligible for services and number of LEP persons likely to be directly affected by its program; language needs of each LEP patient; points of contact where language assistance is needed; and resources needed to provide effective language assistance, including location, availability and arrangements necessary for timely use.

A needs assessment should include information on the cultural beliefs and attitudes of the patient such as the doctor-patient relationship and cultural and religious beliefs regarding health, disease, death, injury, prevention and medical conditions. (see Attachment C for additional areas). This information can come from community organizations, advocates, or public health sources.

Health Care Organizations

Health care organizations should maintain a current demographic cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. Data from government and community sources can be used in developing the demographic profile. The literacy level of the community to be served should also be identified.

Health Care Providers

Health care providers should collect data on the race/ethnicity, country of origin and primary/preferred language of their individual patients; this data should be recorded in the patient's medical file and within the office's management information system.

The needs assessment should lead to the development of a process or strategy with identifiable goals and standards for performance. The health care provider should be strongly encouraged to participate with, or use this data. Both health care providers and organizations must maintain patient confidentiality.

5. Comprehensive Written Policy on Culture & Language

The commitment of health care providers and organizations to cultural and linguistic competence will be systemwide and articulated by comprehensive written policies that guide their practices, procedures and programs. The health care provider and organization can ensure effective communication by developing and implementing a comprehensive written cultural and linguistic access program that includes policies and procedures that identify and assess the language needs of its LEP patients, provide for a range of oral language assistance options, provide notice to LEP patients in a language they can understand of the right to free language assistance, provide for periodic training of staff, assure program monitoring, translate written materials, and address the other key cultural elements identified in these standards.

6. Interpreter Services

Health care providers and organizations must offer and provide competent oral interpretation services at no cost to LEP patients at all points of contact, in a timely manner during all hours of operation subject to law (see Attachment B). Competent oral language assistance services include, in order of preference: qualified bilingual providers and qualified bilingual staff, qualified interpreters, trained volunteers or qualified contracted interpreters, and qualified telephone interpretation services. Telephone interpretation services can be used as a supplement to other interpreter methods but should not be the sole option.

Health care providers and organizations must post written notices, at all key points of contact, that inform patients of the availability of interpreter services at no cost in a language they can understand. Family members and friends should not be used to provide interpretation. Use of minors as interpreters should be discouraged. If the patient declines the provider's interpreter services and requests the use of a family member or friend, the provider may use that person "if the use of such a person would not compromise the effectiveness of services or violate the LEP person's confidentiality. The provider should document the offer and declination in the patient's file. If an LEP person elects to use a family member or friend, the provider should suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation." (Office for Civil Rights Guidance Memorandum).

7. Written Translations – Health Information and Vital Documents

Health care providers and organizations must make available easily understood patient-related information including but not restricted to vital documents (e.g. informed consent and advance directives), health policies, health education and instructional materials.

For example, they must post or provide directional signage and notices informing patients of their right to receive language assistance services at no cost in threshold languages, or

languages of commonly encountered groups and/or groups represented in their service area, subject to law (see Attachment B).

The obligation to provide meaningful access is not limited to written translations. Oral communication is often a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters. LEP individuals should be informed in a language they understand that they have a right to language assistance services and that such services are available. At all points of contact, providers should also distribute written notices with this information and post translated signage.

An effective language assistance program ensures that written material routinely provided in English to patients are available in threshold languages or commonly encountered languages other than English. It is particularly important to ensure that vital documents be translated into threshold languages or commonly encountered non-English languages (see Attachment D).

Materials in threshold languages or commonly encountered languages should be responsive to the cultures and literacy levels of patients. Notice of the availability of competent oral interpretation of written materials to any LEP individuals should be provided at no cost. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments. Signage in commonly encountered languages should provide notices of a variety of patient rights, the availability of conflict and grievance resolution processes, and directions for services.

Health care organizations and relevant governmental agencies (e.g. Department of Consumer Affairs and Department of Health Services) should develop policies and procedures to ensure development of accurate non-English signage and patient-related materials that are appropriate for their target audiences. Health care providers should provide non-English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a qualified and trained individual, back translation and/or review by the local community and target audience groups, and periodic updates. It is important to note that in some circumstances, verbatim translation may not accurately or appropriately convey the substance of what is contained in English written materials.

8. Cultural and Linguistic Competency Training and Continuing Education

Health care organizations have the responsibility to ensure the provision of ongoing education and training in culturally and linguistically appropriate service delivery and practices for staff at all levels and across all disciplines. Training should be appropriate to the level of clinical responsibility of staff. Health care providers have the responsibility to participate in training programs and continuing education that promote culturally and linguistically competent care.

Training of providers and staff is a vital element in ensuring that the cultural and linguistic access policies and procedures are followed, as well as dissemination of the policies to all providers and staff. Effective training assures that providers and staff are: 1) knowledgeable and aware of the policies and procedures; 2) are trained to work effectively with in-person and telephone interpreters; and 3) understand the dynamics of interpretation between providers, patients, and interpreters. Training is one means of ensuring that there is no gap between the written policies and procedures and the actual practices of the providers and front line staff. Training should be part of the orientation for new providers and staff, and all staff in patient contact positions should be properly and regularly trained, preferably on an annual basis.

A number of recommended topics are included in Attachment C.

9. Cultural and Linguistic Program Access Monitoring, Evaluation & Record Keeping

Health care organizations should conduct an annual review and evaluation of their ability to provide culturally and linguistically competent care. Health care providers should access analytical data from health care organizations within their geographical areas of practice and apply this information to their management systems and practices. Each year health care providers and organizations should review the following questions:

- 1) Has the office/organization recorded the language needs of each patient in the patient record?
- 2) Has the office/organization recorded the race, ethnicity, and national origin in the patient record?
- 3) If the office/organization utilizes internal bilingual staff, has the staff been assessed for continuing proficiency in language fluency and the use of medical terminology? If outside interpreters are used, can documentation be obtained that the contracting interpreters are assessed in these skills?
- 4) What documents have been translated and in what languages? Have all translated materials been reviewed to ensure that they are up to date and appropriate?
- 5) Have follow-up appointments been scheduled with LEP patients, and have interpreters been arranged for those appointments?
- 6) Does the office/organization maintain a list of cultural and linguistic resources, and has it been updated in the past year?
- 7) Have translated satisfaction surveys been administered to LEP patients in the past year? Do they indicate a high level of satisfaction?
- 8) Have formal procedures been implemented to allow for an LEP patient to register a complaint or grievance?
- 9) Have the provider and staff participated in continuing education or cultural and linguistic training in the past year? Have they scheduled participation in upcoming trainings?

Health care providers and organizations should ensure that data on the individual patient's race, ethnicity, and spoken and written language are uniformly and consistently collected in health records, integrated into its management information system and periodically updated. The purposes of data collection on race, ethnicity and language are to: 1) adequately identify population groups served; 2) ensure appropriate monitoring of patient needs, utilization, and quality of care, and outcome patterns; 3) prioritize allocation of resources; 4) improve service delivery and planning to enhance access and coordination of care; and 5) ensure that health care services are provided equitably.

Health care providers and health care organizations should conduct patient satisfaction surveys on a regular basis. The surveys should be translated into the languages the clients/patients speak. Surveys should be conducted orally for persons of very low literacy. Questions addressing the level of respect the individual felt when interacting with the provider, and perceived barriers to communication other than language barriers should be included.

10. Organizational Accountability.

Organizational accountability encompasses the broad overarching responsibility of a health organization to provide culturally and linguistically appropriate services for its patients, thereby optimizing their proper diagnostic assessment, treatment and health outcomes. Organizational leaders should develop a comprehensive management strategy including strategic goals, plans, policies, procedures and designated staff responsible for implementation, monitoring and evaluation. Management oversight mechanisms should be developed to ensure frequent updates including an annual report. Key areas for policy and planning should include but not be restricted to the Culturally and Linguistically Appropriate Service (CLAS) Standards proposed by the Office of Minority Health, DHHS. (Attachment E)

Health care organizations should develop participatory and collaborative partnerships with communities in designing and implementing the strategic plan. When conducting its initial and ongoing organizational assessments, the health care organizations should integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. Patient satisfaction surveys should be conducted on a regular basis to evaluate the effectiveness of the program. The organizational assessments should include oversight, monitoring, evaluation and resolution of culturally and linguistically related complaints or grievances as part of the overall quality assurance program for the institution. The quality assurance program should identify and record cultural and linguistic complaints.

The organization should promote a system of recruitment and retention of qualified staff from diverse backgrounds who understand their patient cultures and communities in order to support an organizational culture that can better serve the community. Training opportunities should be made available to assist staff that interacts with patients to increase their cultural knowledge and linguistic skills.

11. Patient Rights

Health care organizations, providers and staff should provide all patients with effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language. Patients have a right to file a grievance or complaint against the health care provider or health care organization for problems associated with not receiving culturally and linguistically competent care.

Health care providers and organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients. This can be accomplished by: 1) providing cultural competence training to staff who handle complaints, grievances, or other legal or ethical conflict issues; 2) providing notice in other languages about the rights of each patient to file a grievance or complaint; 3) providing the contact name and number of the individual responsible for disposition of a grievance or complaint; and 4) for health care organizations, offering ombudsperson services.

Health care providers should provide patients with a document similar to Attachment F for information regarding filing of grievances and complaints.

12. Clinical Assessment of the Patient

Clinical assessment of the patient should include all domains of his/her cultural beliefs, practices, and preferences. In the United States, health care providers are often trained in a medical model - a model of training that focuses on traditional Western, biomedical explanatory models of health. In providing care for culturally diverse patient populations, it is critical to emphasize that other illness perspectives may be the basis of an individual patient's illness experience including traditional cultural perceptions of health, biopsychosocial, and spiritual practices.

Without an understanding of differing perspectives of health, healing and curing, providers may miss opportunities to negotiate effective treatment plans with patients and may miss critical clues in the clinical history that suggests patients' use of alternative therapies or receptivity to alternative healers.

13. Cultural Perspectives on Health and Healing

Health care providers should be able to demonstrate cultural awareness when negotiating treatment plans with patients that incorporate the patient's understanding and perspective of illness, disease and healing. Providers should assume that when communicating with a person of a culture different from their own there might be barriers to perception, understanding and communication, even when the patient and provider can speak the same language. Providers should examine literature from community sources to become familiar with cultural norms that influence a patient's receptivity to given treatments. Providers should ask questions to elicit patient views of illness, such as: What do you call your illness? What do you believe caused your problem? What do you believe will help?

A patient's ability or desire to adhere to a treatment or behavior modification will vary according to his or her worldview and perceptions of the provider's acceptance of that worldview. If a patient senses negative judgments from the provider a distrustful relationship may develop. The process of asking questions and soliciting feelings should continue at all stages of the process of seeing the patient, including after prescribed treatments. Periodic follow-ups are essential, as well as follow-up questions, including: How do you feel about taking these medications? Do you believe that following the advice I've given will make you feel better? Can you do this? What do you understand about how your treatment plan will work?

ATTACHMENT A

AB 2394 GLOSSARY

Glossary

The Working Group on Cultural Competency Standards provides this glossary to facilitate clarity and understanding of this document.

Access: the degree to which services are readily obtainable – determined by the extent to which needed services are available, information about these services is provided, the responsiveness of the system to individual cultural and linguistic needs, and the convenience and timeliness with which services are obtained.

Back Translation: a process that ensures accuracy of a translation of source language (e.g. English) into a target language (e.g. Spanish) by translating back to the source language.

Cultural Awareness: the development of sensitivity and understanding of other diverse groups. It usually involves changes within an individual toward others in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that a person develops in relation with others. Cultural awareness should be supplemented with knowledge of cultures different from one's own.

Cultural Competency: the delivery of culturally competent health care incorporates pertinent cultural concepts and data in the clinical assessment and treatment of individuals across ethnic and cultural groups. At a minimum, cultural competency skills include:

- Applying linguistic skills to communicate effectively with the target population;
- Utilizing cultural information to establish therapeutic relationships;
- Eliciting and incorporating pertinent cultural data in diagnosis and treatment; and
- Understanding and applying cultural and ethnic data to the process of clinical care.

Cultural Diversity: a constellation of people consisting of distinctive ethnic groups, colors and races, languages, customs, styles, values, beliefs, gender, ages, education, knowledge, skills, abilities, functions, practices, religions, socioeconomic status, sexual orientation and geographic areas.

Cultural Sensitivity: recognition and respect for customs and cultural norms different from one's own.

Culture: the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people. Culture influences how clinicians deliver services and how patients respond to medical services and preventive interventions. Culture is determined not only by race or ethnicity but by factors such as national origin, geography, age, language, religion, gender, sexual orientation, physical ability and socioeconomic status. Individuals may identify with more than one

cultural group. There are six essential elements of culture:

- Culture is learned
- Culture refers to systems of meanings
- Culture acts as a framework upon which belief systems are built.
- Culture is taught and reproduced and may be transmitted intergenerationally
- Culture exists in a constant state of change
- Culture includes patterns of both subjective and objective components of human behavior.

Health Care Organizations: for the purposes of this document, any entity that provides health care services including medical groups, managed care plans, hospitals, clinics and other facilities.

Health Care Provider: for the purposes of this document, any entity or individual who provides health care services such as physicians, dentists and their staff.

Interpretation: involves conveying both the literal meaning and connotations of spoken and unspoken communication (e.g. body language, mannerisms) from one language into another to the health practitioner and the patient.

Limited English Proficient (LEP): an LEP individual is a person who is unable to speak, read, write or understand the English language at a level that permits him/her to interact effectively with health and social service agencies and providers.

Linguistic Competency: the health care organization's ability to provide its non and limited English speaking patients and hearing/speech impaired patients with timely, accurate and confidential interpretation services, and quality, culturally appropriate translated materials.

Linguistic Proficiency: proficiency in English and the target language.

Multicultural: consisting of cultural characteristics representative of one or more culturally diverse groups. Multicultural individuals may acquire the norms, attitudes and behavior patterns of their own and one or more ethnic and/or cultural groups.

Preferred Language: refers to the language an individual is most proficient in and uses most frequently to communicate with others inside and outside the family system.

Qualified Translator: One who is able to read, write, and understand both the target language(s) and English; has knowledge and experience with the culture(s) of the intended audience; and has knowledge of medical terminology.

Threshold Language: a language that meets any federal, state or local statutory or regulatory definition. (See Attachment B on Relevant Laws, Policies and Accreditation Requirements)

Translation: The rendering, in writing, of a written text from one language to another.

Adapted from Los Angeles County, Department of Health Services Cultural and Linguistic Competency Standards.

ATTACHMENT B

Summary of Relevant Laws, Policies and Accreditation Requirements

Health programs and services are required to provide culturally and linguistically competent care under numerous legal, regulatory, contract and accreditation authorities. Many of these requirements have been in effect for years; other requirements are recent, driven by the continuing diversification of the U.S. and California populations. Following is a brief summary of these requirements

Federal

All recipients of federal financial assistance are subject to *Title VI of the Civil Rights Act of 1964* (42 U.S.C. § 2000d et seq.) and to the U.S. Department of Health and Human Services (HHS) Title VI regulations at 45 C.F.R. Part 80. Title VI and the HHS regulations prohibit discrimination on the basis of race, color, or national origin in any program or activity that receives federal financial assistance. Title VI has been consistently interpreted by courts and federal agencies to protect limited English proficient (LEP) persons.

The HHS Office for Civil Rights (OCR) provides technical assistance to federal fund recipients seeking to make their programs and services accessible to LEP persons. OCR also monitors and enforces compliance with Title VI, primarily through responding to complaints received. On August 30, 2000 and January 2002, OCR issued written policy guidance to assist health and social service providers in delivering meaningful access to services for LEP persons. The guidance, published in the Federal Register by the OCR, outlines the legal responsibilities of providers who receive federal financial assistance from HHS to assist people with limited English proficiency. The guidance reviews four keys to compliance with Title VI:

- (1) Assessment of need
- (2) Development of a comprehensive written language access policy
- (3) Training of staff
- (4) Monitoring.

Executive Order 13166 issued on August 11, 2000 outlines requirements to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency.

The Hill-Burton Act, Medicaid, Medicare, and community health clinic standards also require appropriate language services for limited English proficient patients.

State

Numerous state laws and regulations require health care providers to make health care programs and services linguistically accessible.

The Dymally-Alatorre Bilingual Services Act (Cal.Gov't. Code § 7290 et seq.) imposes direct obligations on state and local agencies to provide oral interpreter services and translated materials.

The Kopp Act (Cal. Health & Safety Code § 1259) requires acute care hospitals to take numerous steps to serve LEP patients, including:

- Adopting and annually reviewing a policy for providing language assistance services to limited English patients

- Ensuring availability of interpretation on site on a 24-hour basis to the extent possible as determined by the facility
- Posting notices
- Identifying and recording a patient's primary/preferred language and dialect
- Preparing and maintaining a list of interpreters
- Notifying employees of the hospital's commitment to provide interpreters.

In addition, there are provisions in other state laws imposing language access requirements in specific programs or services.

Other State Requirements

In April 1999, the California State Medi-Cal Managed Care Division released *Policy Letters 99-01 to 99-04* and an *All Plan Letter 99-05* that clarify requirements of Medi-Cal Managed Care Plans. The requirements include:

- Implementing and maintaining a Community Advisory Committee;
- Conducting health education and cultural and linguistic needs assessments;
- Providing linguistic services; and
- Translating written documents.

These letters present guidelines to assist plans in building systems that meet the needs of the diverse Medi-Cal population. Each health plan is encouraged to demonstrate continuing progress towards attaining a higher level of organizational cultural competency that is conducive to improving health care access and service delivery to its members.

Similar to Medi-Cal, the Healthy Families program has also set forth cultural and linguistic competency requirements for Healthy Families contractors. In December 1999, the Managed Risk Medical Insurance Board (MRMIB), which administers the Healthy Families program, issued specific requirements including:

- Prohibiting the use of minors to interpret except in the most extraordinary circumstances;
- Requiring 24-hour access to interpreters; and
- Requiring demonstrated bilingual proficiency by providers who list their bilingual capabilities.

Accreditation Requirements

Many health care providers must also meet cultural and linguistic competency requirements to maintain certification by private accrediting agencies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA), which acknowledge that a key quality of care issue for culturally diverse populations and persons who speak little or no English is the provision of culturally and linguistically appropriate services. In the delivery of health care, all patients have the same rights regardless of race, ethnicity, national origin and Limited English Proficiency.

Adapted from Los Angeles County, Department of Health Services Cultural and Linguistic Competency Standards.

ATTACHMENT C

Recommended topics for Cultural Competency Training and Continuing Education Programs for Physicians and Dentists include but are not limited to:

- A. Understanding the application and concept of culture in clinical care.
- B. Elicitation of pertinent cultural information in interviews to make a diagnosis and formulate a treatment plan.
- C. How to work with an interpreter and interpreter ethics.
- D. Eliciting basic ethnic and cultural information necessary for needs assessment and data collection: language and dialect spoken, degree of English-speaking skills, key informants, and key decision-maker in family, etc.
- E. Effects of diets and herbs on drugs
- F. Cross-Cultural Pharmacology: Pharmacokinetic, Pharmacogenetic, Pharmacodynamic findings that may affect drug actions and metabolisms and drug/drug interaction.
- G. Cultural aspects of Physician/Dentist - Patient relationship.
- H. Cultural aspects of diagnostic categories.
- I. Cultural factors in the expression of illnesses.
- J. Cultural factors of family responses to illness in members of family.
- K. Cultural and community responses to illness.
- L. Cultural factors in healing experience.
- M. Aspects of symbolic healing.
- N. Role of indigenous healers in healing system.
- O. Alternative Medicine: Facts and Myths.
- P. Role of traditional medical systems, classical and popular, in contemporary health care system.
- Q. Cultural factors in the biopsychosocial paradigm in diagnosis and treatment.
- R. Health beliefs, food beliefs, and concepts of illness.
- S. Historical background of immigrants groups.
- T. General Physical and Psychiatric Sequelae of Trauma, Dislocation and Severe Culture Shock of immigrant groups.
- U. Epidemiology of diseases/disorders of various ethnic groups.
- V. Culture-Bound Syndromes.
- W. Use of Cultural Formulation in Psychiatric and Medical Care.
- X. How to use cultural information in life-long learning.
- Y. Basic manners, linguistic, and social interaction of various ethnic groups and their pertinence to provider/consumer interaction.
- Z. Cultural aspects of medication adherence/non-adherence, and psychotherapy.
- AA. Racial disparities in health.
- BB. Access to health care.

ATTACHMENT D

Examples of documents requiring translation include but are not limited to:

- ▶ Signage and way-finding directions
- ▶ Patient intake forms
- ▶ Consent forms for, but not limited to, the following examples: medical treatment, surgery, anesthesia, inpatient psychiatric treatment, and diagnostic tests
- ▶ Advance directives
- ▶ Patient complaint forms
- ▶ Letters and notices pertaining to the reduction, denial or termination of services or benefits
- ▶ Letters or notices that require a response from the beneficiary or client
- ▶ Documents that advise of free language assistance
- ▶ Billing and financial information
- ▶ Patient rights and responsibilities
- ▶ General information on current clinical trials being conducted within the facility and opportunities to participate
- ▶ Applications for financial assistance, social services, case management
- ▶ Consents to release medical information
- ▶ Appointment reminder notices
- ▶ Health education materials, or
- ▶ Any documents affecting the medical treatment or legal rights of a patient
- ▶ In-patient stay: Permission for hospitalization and Patient's Abuse Policy
- ▶ Outpatient: Physicians' and dentists' responsibility, including ethics

Threshold languages; safe harbors; qualified translation process; vital v. other documents (def. OCR & AB 2739)

ATTACHMENT E

National Culturally and Linguistically Appropriate Services (CLAS) Standards Office of Minority Health, U.S. Department of Health & Human Services (2000)

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Healthcare organizations should ensure that staffs at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organization must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organization self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic cultural and epidemiological profile of the community as well as a need assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

ATTACHMENT F

Filing a Complaint Based on Discrimination with the Office for Civil Rights

If you believe that you have been discriminated against because of your race, color, or national origin, including language, you may file a written complaint with the Office for Civil Rights (OCR). The complaint should be filed within 180 days of the act you want to complain about, but you may be able to file after the 180 days in some cases. Under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act and the Americans with Disabilities Act, the OCR protects people from discrimination by health care and human service providers that receive federal funds from the U.S. Department of Health and Human Services. Medicare and Medicaid (Medi-Cal in California) are some examples of federal funds. There are many programs that cannot discriminate based on language or disability.

For California, you should call the Region IX office and ask for a complaint form packet at (415) 556-8367 or call the toll-free number: 1 (800) 368-1019, TDD: (415) 437-8311. You can write the office at:

Regional Office for Civil Rights, Region IX
50 United Nations Plaza, Room 322
San Francisco, CA 94102

Filing a Complaint with a State Licensing Board

Professional licensing boards issue licenses and review complaints by patients that can affect the practice of a professional.

Medical Board of California
Attn: Central Complaint Unit
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Phone: (916) 263-2382 or (800) 633-2322
Website: www.medbd.ca.gov

Dental Board of California
1432 Howe Avenue, Suite 85-B
Sacramento, CA 95825
Phone: (916) 263-2300
Website: www.dbc.ca.gov

Board of Psychology
1422 Howe Avenue
Sacramento, CA 95825-3200
Phone: (916) 263-2699

Board of Registered Nursing
400 R Street, Suite 4030
Sacramento, CA 95814
Phone: (916) 322-3350

Licensed Vocational Nurses and Psychiatric Board/
Vocational Nurses and Psychiatric Technicians
2535 Capitol Oaks Drive, Suite 205
Sacramento, CA 95833-2919
Phone: (916) 263-7822

Health Issues and State Agencies

Below is a list of some of the state agencies that can review patient complaints:

Department of Managed Health Care (handles complaints against a health plan)
(800) 400-0815

Department of Mental Health
Health Plan Ombudsman Services
(handles Medi-Cal complaints)
(800) 896-4042

Department of Health Services, Medi-Cal Managed Care Ombudsman (provides assistance in investigating and resolving any grievances involving a Medi-Cal recipient.
(888) 452-8609.

Department of Social Services, Public Inquiry and Response Unit (the Medi-Cal recipient has the right to request a fair hearing)
(800) 952-5253, TDD (800) 952-8349.

Department of Health Services, Licensing and Certification (Complaints about violations of interpreter services required by the Kopp Act)
(916) 229-3400 or see local directory for other district offices.

California Department of Aging
Office of the State Long Term Care Ombudsman
1600 K Street
Sacramento, CA 95814
Phone: (916) 323-6681 or (800) 231-4024

Non-profit Advocacy Agencies

Protection and Advocacy, Inc.
Phone: (916) 488-9950 or (800) 776-5746

For people with psychiatric disabilities and patient rights violations:
Look in the phone book for the county office of patient rights

Office of Patient Rights
Phone (916) 575-1625 or (888) 732-2225

Health Consumer Alliance

The Health Consumer Alliance is a partnership of consumer assistance programs operated by community-based legal service organizations whose mission is to help low-income people obtain essential health care:

- 1) Fresno Health Consumer Center
2014 Tulare St., Suite 502
Fresno, CA 93721
(800) 300-1277
- 2) Health Consumer Center of Los Angeles
13327 VanNuys Blvd
Pacoima, CA 91331
(800) 896-3203
- 3) Orange County Health Consumer Action Center
902 N. Main St.
Santa Ana, CA 92701
(800) 834-5001 or (714) 571-5200
- 4) Consumer Center for Health Education and Advocacy
1475 6th Ave., 4th Floor.
San Diego, CA 92101
(877) 734-3258
- 5) Community Health Advocacy Project
50 Fell St., 1st Floor.
San Francisco, CA 94102
(800) 551-5554 or (415) 982-1300
- 6) Health Consumer Center of San Mateo County
521 East 5th Ave.
San Mateo, CA 94402
(800) 381-8898 or (650) 558-0915 or (650) 558-0786 (TDD)
- 7) Support Centers:
 - a) National Health Law Program
2639 South La Cienega Blvd
Los Angeles, CA 90034
(310) 204-6010
 - b) Western Center On Law and Poverty
3701 Wilshire Blvd., Suite 208
Los Angeles, CA 90010
(213) 487-7211